# The art of communication: Getting back to basics

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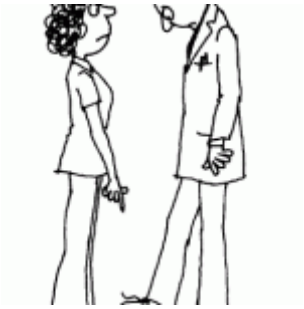
Communication is defined in the Merriman-Webster dictionary as a verbal or written message,



Face-to-face verbal interactions offer CDI specialists unique physician education opportunities.

exchange of information, or a process by which information is exchanged between individuals through a common system of symbols, signs, or behavior. Consider the evolution of communication within the last century, beginning with the carrying of mail by horse and buggy, then the introduction of the telegraph, telephone, fax machine, and now the internet.

Now consider the evolution of communication as pertains to coding and clinical documentation improvement (CDI). Before the advent and growth of CDI programs, documentation improvement consisted of a retrospective coding query to the physician. The query sought clarification of principal and secondary diagnoses consisting of complications and comorbidities (CCs).

Today, CDI programs shine a light need to educate physicians about complete and accurate clinical documentation. CDI programs highlight that need in the face of increased coding and billing regulatory scrutiny as well as a sound, prudent business strategy to meet the business financial challenges faced by physicians. Savvy CDI specialists therefor have incorporated educational tools into their programs including monthly newsletters, tip sheets, and pocket guides.

The execution of effective communication strategies dictates the successes and failures of a given CDI program. As I have the opportunity to "observe" programs in action, one component of communication often seems to be lacking. This component includes old fashioned verbal communication with physicians about the clinical facts of the case, existing documentation, and possible clinical documentation that may be missing from the health record.

Verbal communication allows the CDI specialist to provide education and reinforce teaching principles, a key point missing from the use of written clinical queries. The use of verbal communication allows the CDI specialist to read the physician's body language and other cues to determine whether the physician understands the principles being discussed.

Appreciation and understanding of these documentation principles by the physician serves as the basis for educational reinforcement of other tools used in physician clinical documentation improvement efforts, the likes of newsletters, tip sheets, handouts, etc. No clinical documentation improvement program can be successful in the long run without going beyond episodic education of continuous, repetitive clinical queries. Eventually, physicians have a tendency to grow weary of the same day in, day out queries. They become numb to the content.

Physician clinical behavior modification by necessity requires more than leaving queries in the record for the physician to review at a later time. If one thinks about the use of clinical queries, an argument can be made for the evolution of clinical clarification to merely have changed from retrospective to concurrent. The physician is reading the clinical query on the hospital floor as opposed to reading it, culling information post-discharge, from the medical records.

Consider varying and adjusting CDI specialists' work schedule to improve likelihood of reaching out to physician's individual patient rounding practices. Reaching out to physicians for provisions of providing education is best served through learning of these practice patterns and adjusting one's schedule accordingly. Generally speaking, making clinical documentation rounds routinely from 8 a.m. to 5 p.m., with a predetermined lunch break misses out on the opportunity to effectively and efficiently fulfill the roles, goals, and objectives of any program, that is true clinical documentation improvement.

Good Luck.